PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPL	ETED
		15G466	A. BUII B. WIN			10/08/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ 75TH PL		
REM-IND	DIANA INC				IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0000							
	This is a C		1110	000			
	This visit was for a predetermined full annual recertification and state licensure			000			
	survey.						
	This visit was done in conjunction with						
	the PCR (Post Certification Revisit) for						
	the investigation of complaint						
	#IN00112797 c	ompleted on 8/24/12.					
	Dates of Survey	r: 10/1/12, 10/2/12,					
	10/3/12 and 10/	8/12.					
	Facility Number	r: 000980					
	Provider Number						
	AIMS Number:						
	THING I WILLOUT.	100211020					
	Surveyor:						
	1	edical Surveyor III					
	Keini Billiei, M	edical bulveyof III					
	These deficience	ies also reflect state					
	illidings in acco	rdance with 460 IAC 9.					
	Onelite and in	1111111					
		completed October 15,					
	1 -	Walton, Medical Surveyor					
	III.						
	I		- 1		Ī		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED	
		15G466	B. WIN			10/08/	2012	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				/ 75TH PL			
REM-IND	IANA INC				IAPOLIS, IN 46260			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
TAG W0104	483.410(a)(1) GOVERNING BC The governing borolicy, budget, and the facility. Based on record 3 of 3 sampled of three additional of governing body policy, budgeting over the facility. B's finances were predetermined mallowed by Media body failed to extend budgeting and of the facility to assaccounting of cliffs finances and missing funds (or governing body policy, budgeting over the facility nursing services with necessary attraining/methodo plans. Findings include 1. Client A's finance includes 1. Client A's finance includes	ody must exercise general and operating direction over review and interview for lients (A, B and C) plus clients (D, E and F), the failed to exercise general g and operating direction to ensure clients A and e not in excess of maximum amounts icaid. The governing tercise general policy, operating direction over sure a full and complete tent's A, B, C, D, E, and failed to reimburse lients D, E, and F). The failed to exercise general g and operating direction by failing to ensure their provided clients B and C daptive equipment and ologies in their program	W0		1. The Home Manager and Program Director will complete audit of all consumers finances to determine if anyone's accoubalance is in excess of the allowable amount. If any consumers account balances a in excess of the allowable amount the Home Manager and Program Director will work with the Soci Worker and Client Finance Specialist to spend the money an appropriate manner to get to balance below the allowable amount. 2. The Home Manager and Program Director will complete audit of all consumers finances ensure that petty cash ledgers are updated and maintained for all clients. 3. Paperwork has been completed for Client D, E and get reimburse for missing fund Area Director will follow up with Accounting Department to che on the status of consumers getting reimbursed for missing money. The Home Manager and Programoney.	e an s, ant are punt aid in the e at to br F to s. h ck	11/07/2012	
		rative staff in the agency			Director will receive retraining consumers finances including	011		
		0/12 through 10/2/12			ensuring that all consumers			
		-	1		i .		Ī	

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Event ID: 6S6P11

Facility ID: 000980

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		15G466	A. BUII B. WIN			10/08/2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8				
	NANIA INIO				75TH PL	
KEW-INL	DIANA INC			INDIAN	APOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	indicated the fol	lowing:			accounts are below the allowa	ble
		2			amount and that Petty cash	
	8/20/12 DDW/	(Poom and Poord			ledgers are up to date and are	
	-8/20/12, RBW (Room and Board				maintained monthly for all	
	Withdrawal), \$28.00 with an ending				consumers financial transaction	ns.
	balance in the ar	nount of \$5,358.04			Ongoing the Olivet Fires	
					Ongoing the Client Finance	
	-8/20/12, RBW,	\$28.00 with an ending			Specialist will provide a record monthly to the Area Director or	
	· · · · · · · · · · · · · · · · · · ·	nount of \$5,330.04			consumers that have an accou	
		+			balance in excess of the	,
	-9/11/12, RBW, \$28.00 with an ending balance in the amount of \$5,302.04				allowable amount. The Area	
					Director will ensure that the	
	balance in the an	nount of \$5,302.04			Program Director and Home	
					Manager are notified so the ca	ın
	Client B's financial record was reviewed				work with the Social Worker ar	
	on 10/2/12 at 11	:48 AM. Client B's			Client Finance Specialist to sp	end
		ister account ledger dated			the money in an appropriate	
	_	10/2/12 indicated the			manner to get the balance belo	
	_	10/2/12 mulcated the			the allowable amount. Ongoing	-
	following:				the Home manager will review clients finances a minimum of	tne
					weekly to ensure that Petty ca	eh
	-7/17/12, SSD (S	Social Security Deposit),			ledgers are up to date. The	311
	\$6,187.00 with a	in ending balance in the			Program Director will review a	nd
	amount of \$9,36	1.54			reconcile the finances a minim	
	,. ,. ,.				of monthly to ensure that all	
	 _7/17/12	6465.00 with an ending			records are up to date and	
					accurate.	
	balance in the ar	nount of \$9,826.54				
					Responsible Party: Home	
	-7/17/12, RBW,	\$1,089.00 with an ending			Manager, Program Director, A	
	balance in the ar	nount of \$8,737.54			Director, Client Finance Specia	alist
	-8/3/12 SSD \$9	3.00 with an ending				
		nount of \$8,830.54				
		110unt 01 \$0,030.34				
	0.10.16.5					
		,239.00 with an ending				
	balance in the ar	mount of \$10,069.54				
			- 1		I	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE	ΣΥ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G466	B. WIN	G		10/08/2012	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
DEM. 13.15					75TH PL		
REM-INL	DIANA INC			INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		OATE
		\$1,089.00 with an ending					
	balance in the ar	mount of \$8,980.54					
	0/21/12 CCD #	202.00 ::1 1:					
-8/31/12, SSD, \$93.00 with an ending							
	balance in the amount of \$9,073.54						
	9/21/12 CCD ©	\$1,239.00 with an ending					
	1 1	,					
	Darance in the ar	mount of \$10,312.54					
	0/11/12 DDW	\$1,089.00 with an ending					
		nount of \$9,223.54					
	balance in the ar	110unt 01 \$9,223.34					
	2 Client A's fin	ancial record was					
		2/12 at 11:48 AM. Client					
		ord did not indicate a					
		ntained petty cash ledger					
	1 ~ ^	, September 2012 and/or					
	through 10/2/12/						
	unrough 10/2/12/	date of feview.					
	Client R's financ	cial record was reviewed					
		:49 AM. Client B's					
		did not indicate a group					
		d petty cash ledger for					
		eptember 2012 and/or					
	through 10/2/12/	-					
	unrough 10/2/12/	ruale of feview.					
	 Client C's financ	cial record was reviewed					
		:50 AM. Client C's					
		did not indicate a group					
		d petty cash ledger for					
		eptember 2012 and/or					
	"	*					
	through 10/2/12/	uaic 01 ICVICW.					
	3 The facility's	BDDS (Bureau of					
	J. The facility S	DDDD (Dureau OI					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G466	B. WIN	_		10/08/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
	NANIA INIC				75TH PL		
REM-INL	DIANA INC			INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
TAG		*	+	TAG			DATE
		Disabilities Services)					
	reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review						
	indicated the following:						
	-BDDS report dated 9/11/12 indicated,						
	"Money was given to staff on the evening						
		· ·					
	of 9/7/12 and put in a lock box. Later that						
	evening staff took some of the consumers to the gas station. The next morning when						
	staff went to take the consumers out						
	[client D] was missing \$5.00, [client E]						
		00 and [client F] was					
	missing \$5.00."	oo and [enent 1] was					
	missing \$5.00.						
	AS (Administrat	ive Staff) #1 was					
	`	0/2/12 at 11:48 AM. AS					
		maximum allowable					
		500.00. AS #1 indicated					
		nces for client A and					
		excess of the allowable					
		indicated client's D, E					
		en reimbursed their					
		AS #1 indicated the					
		be reimbursed the					
		AS #1 stated, "We do					
	1	ecounting of funds					
		ot in the group home). We					
	_ ` -	nanagers, it was a mess					
		r. We have been in the					
		ciling funds and ledgers."					
	1 222 22 22 20001	9					
	The governing h	ody failed to exercise					
	1 -	oudgeting and operating					
	Strict in pointy, o						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		15G466	B. WING		10/08/2012			
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE				
ם בא ואים	NANA INC			V 75TH PL				
	DIANA INC			NAPOLIS, IN 46260				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION			
TAG		·	TAG	DEI CHERCT)	DATE			
		ne facility by failing to						
		sing services provided						
		with necessary adaptive						
		raining/methodologies in						
	their program pl							
	Please see W33	1.						
	0.2.1(a)							
	9-3-1(a)							

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Event ID: 6S6P11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				75TH PL		
REM-IND	DIANA INC				APOLIS, IN 46260		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0125	483.420(a)(3) PROTECTION Of The facility must of clients. Therefore and encourage in their rights as clients of the Unright to file complay process. Based on observation interview for 3 of and C), the facility clients' rights we restricting their and due process through individual need. Findings include Observations we home on 10/1/12 of 100 PM. At 5:10 assisting clients of preparation in the Staff #1 exited the group home living medication cabing approached the marea where staff in medication for accurate where staff in the medication cabing approached the marea where staff in the medication cabing approached the marea where staff in the medication cabing approached the marea where staff in the medication cabing approached the medication cabing	F CLIENTS RIGHTS ensure the rights of all e, the facility must allow dividual clients to exercise ents of the facility, and as ited States, including the aints, and the right to due ation, record review and f 3 sampled clients (A, B ty failed to ensure the ere not violated by excess to knives without ugh assessment of : re conducted at the group from 4:51 PM through D PM staff #1 was with the evening meal e group home kitchen. he kitchen and entered the enter was located. Staff #1 medication administration #2 was preparing dministration and stated, and removed a knife from abinet. At 5:45 PM staff hife at the kitchen sink knife to the medication	Wo		The Program Director will reviet the need for all consumers regarding restricted access to knives in the home. If it is determined that any consumer need restricted access, the Program Director will ensure the restriction is put into the consumers Behavior Support Plan and guardian and Humar Rights Committee Approval is obtained. For other consumer that do not require restricted access to the knives in the hor the Home Manager and Program Director will develop a way for them to have access to the knives as needed such as have a key to where the knives are locked up. The Home Manager and Program Director will receive retraining not violating consumers rights restricting access to the knives the home with out due process through assessment of individing need. Ongoing, the Home Manager and Program Director will ensure the all consumers rights are not violated by restricting access to	the rs nat rs me, am ing ram on by s in s ual	11/07/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G466	A. BUILDING B. WING			COMPLETED 10/08/2012	
	PROVIDER OR SUPPLIER			1926 W	ADDRESS, CITY, STATE, ZIP CODE 775TH PL APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
IAU	Client A's record 10/2/12 at 12:14 (Individual Supp did not indicate or required to be resund/or use of kninot indicate a BS Plan). Client A's Functional Assess not indicate the result to knives. Client indicate HRC (Happroval for accerestricted. Client B's record 10/2/12 at 10:08 3/23/12 did not into be restricted from use of knives. Client to be restricted from a knives. Client B's HRC approval for restricted.	was reviewed on PM. Client A's ISP ort Plan) dated 8/11/11 client A needed or stricted from access ves. Client A's record did P (Behavior Support CFA (Comprehensive Isment) dated 7/27/09 did Iteed for restricted access A's record did not Is uman Rights Committee) cess to knives to be was reviewed on AM. Client B's ISP dated andicate client B needed from access to and/or the itent B's BSP dated andicate client B needed from access to and/or the itent B's undated CFA did at B needed to be coess to and/or the use of s record did not indicate or access to knives to be		IAU	anything unless determined by the IDT and approval obtained from guardian (if needed) and Human Rights Committee. Responsible Parties: Home Manager, Program Director	<u> </u>	DATE
	10/2/12 at 1:09 P 2/7/12 did not inc be restricted from	PM. Client C's ISP dated dicate client C needed to a access to and/or the use C's BSP dated 9/1/12					

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PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G466	A. BUILDING A. WING	TION	(X3) DATE SURVEY COMPLETED 10/08/2012
	PROVIDER OR SUPPLIER DIANA INC	B. WING STREET ADDRESS 1926 W 75TH INDIANAPOLIS		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX (EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's CFA dated 4/22/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's record did not indicate HRC approval for access to knives to be restricted. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated the group home locked the knives in the medication cabinet. QMRP #1 indicated clients A, B and C did not have product misuse or history of misuse/threat of use of knives as weapons. QMRP #1 indicated client A, B and C did not have a key to access the knives in the house. 9-3-2(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G466	B. WIN			10/08/2012
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				/ 75TH PL	
REM-IND	DIANA INC				IAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0140	483.420(b)(1)(i)					
	CLIENT FINANCI					
		establish and maintain a res a full and complete				
		nts' personal funds				
		acility on behalf of clients.				
	Based on record	review and interview for	W0	140		11/07/2012
	3 of 3 sampled c	lients (A, B and C) plus 3			1. The Home Manager and	
		s (D, E and F), the facility			Program Director will complete	
		full and complete			audit of all consumers finances to determine if anyone's account	
		ents' finances and failed			balance is in excess of the	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	to reimburse mis				allowable amount. If any	
	to remiourse mis	sing runds.			consumers account balances	are
	Findings in stude				in excess of the allowable amo	
	Findings include	:			the Home Manager and Progra	
					Director will work with the Soci	al
		incial record was			Worker and Client Finance Specialist to spend the money	in
		2/12 at 11:48 AM. Client			an appropriate manner to get t	
	A's financial reco	ord did not indicate a			balance below the allowable	
	group home main	ntained petty cash ledger			amount.	
	for August 2012,	, September 2012 and/or				
	through 10/2/12/	date of review.			2. The Home Manager and	
	-				Program Director will complete audit of all consumers finance:	
	2. Client B's fina	ncial record was			ensure that petty cash ledgers	
	reviewed on 10/2	2/12 at 11:49 AM. Client			are updated and maintained for	
		ord did not indicate a			all clients.	
		ntained petty cash ledger				
	1 ~ 1	September 2012 and/or			3. Paperwork has been	_,
		•			completed for Client D, E and get reimburse for missing fund	
	through 10/2/12/	date of feview.			Area Director will follow up with	
	2 01: 01: 0				Accounting Department to che	
	3. Client C's fina				on the status of consumers	
		2/12 at 11:50 AM. Client			getting reimbursed for missing	
	C's financial reco	ord did not indicate a			money.	
	group home main	ntained petty cash ledger			The Home Manager and Progr	
	for August 2012,	, September 2012 and/or			Director will receive retraining consumers finances including	OII
	through 10/2/12/	date of review.			ensuring that all consumers	

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Facility ID: 000980

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		ONSTRUCTION 00	(X3) DATE S COMPLE	ETED
		15G466	B. WIN	G		10/08/2	2012
REM-IN	PROVIDER OR SUPPLIER			1926 W INDIAN	ADDRESS, CITY, STATE, ZIP CODE 75TH PL APOLIS, IN 46260		410
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Developmental I reports and invest on 10/2/12 at 8:5 indicated the following indicated the following the properties of 9/7/12 and pure evening staff too to the gas station staff went to take [client D] was massing \$5.0 missing	ated 9/11/12 indicated, en to staff on the evening t in a lock box. Later that ak some of the consumers at The next morning when the the consumers out issing \$5.00, [client E] 00 and [client F] was ive Staff) #1 was 0/2/12 at 11:48 AM. AS nt's D, E and F had not their missing money. AS clients' needed to be missing money. AS #1 ot have a full accounting thome cash accounts for C). We switched home a mess not accounted en in the process of			accounts are below the allowal amount and that Petty cash ledgers are up to date and are maintained monthly for all consumers financial transaction. Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so the cast work with the Social Worker at Client Finance Specialist to specifient Finance Specialist to specifient allowable amount. Ongoing the Home manager will review clients finances a minimum of weekly to ensure that Petty calledgers are up to date. The Program Director will review a reconcile the finances a minimum of monthly to ensure that all records are up to date and accurate. Responsible Party: Home Manager, Program Director, A Director, Client Finance Special	ons. If all unt ow g, the sh nd um	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G466	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 08/2012	
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G466		(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 10/08/	ETED	
	PROVIDER OR SUPPLIER DIANA INC			1926 W	75TH PL APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0153	The facility must of mistreatment, rinjuries of unknow immediately to the officials in accord through establish. Based on record 2 of 17 allegation or neglect review immediately not Developmental I accordance with incident of medic client B. The facility incident of medic client B. The facility is and Findings include. The facility's BD investigations we at 8:50 AM. The following: -BDDS follow up indicated, "[client following medicated, "[client follo	review and interview for as of abuse, mistreatment wed, the facility failed to affy BDDS (Bureau of Disabilities Services) in state law regarding an eation omission regarding ality failed to affy BDDS in accordance garding an incident of F's missing petty cash. DDS reports and ere reviewed on 10/2/12 review indicated the preport dated 8/31/12 at B] missed the ations: Oyster Shell tamin D 500 milligrams	WO	153	All Direct care staff will be rece retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in whici incidents are to be reported are the procedure for immediately notifying the on call supervisor reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support record behavior tracking and narrative notes to ensure all incidents thave been documented have been reported to the Program Director so reports can be made to the Bureau of Development Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behaviot tracking records a minimum of twice weekly for 30 days to ensure that all incidents that faunder the BDDS reportable incident guidelines are reported the on call supervisor, Program Director and/or Area Director	th and	11/07/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		15G466	B. WIN			10/08/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t .		1926 W	75TH PL		
	DIANA INC			<u> </u>	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	within the designated reporting	, +	DATE
		rding the medication			guidelines. After the 30 days, t		
	error. [Staff #1]				Home Manager and/or Progra		
	`	still in the cabinet but			Director will review the DSRs a		
	[staff #2] had sig				Behavior tracking records a		
		given). On-call nurse			minimum of once per week to		
		informed the house nurse on 8/27/12.			ensure that all incidents that faunder the BDDS reportable	···	
	This home is in between home managers and although one home manager is helping cover the home the 6 day difference is due to a miscommunication. Program director was not made aware of the error and able to get clarification until 8/29/12 and made the report right away."				incident guidelines are reporte	d to	
					the on call supervisor, Prograr		
					Director and/or Area Director		
					within the designated reporting	9	
					guidelines.		
					Responsible Party: Home		
					Manager, Program Director, A Director	rea	
	RDDS report de	ated 9/11/12 indicated,					
	1	en to staff on the evening					
		t in a lock box. Later that					
	_	ok some of the consumers					
		n. The next morning when					
		e the consumers out					
		issing \$5.00, [client E]					
	was missing \$5.0	00 and [client F] was					
	missing \$5.00."						
	Interview with	S (Administrative Staff)					
		AS (Administrative Staff) 11:14 AM indicated					
		e incidents included					
		sions and clients' missing					
	1 ^ -	. AS #2 indicated BDDS					
	reportable incidents should be reported to						
	BDDS within 24	hours of the incident.					
	9-3-1(b)(5)						
	9-3-1(b)(3) 9-3-2(a)						
) 5 2(u)		1				

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM	ee survey Pleted 18/2012		
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP (' 75TH PL	CODE			
	IANA INC		INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 10/08/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	10/00/	2012
REM-IND	DIANA INC				/ 75TH PL JAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0159	PROFESSIONAL Each client's active be integrated, coordinate client and C), the QMR Retardation Professions and C), the QMR Retardation Professions and C and	re treatment program must predinated and monitored by retardation professional. Patients (A, B) and clients (B) and	W0	159	1. All Direct Care staff will recretraining on all consumers Medication Administration goand the need to complete forr training goals as indicated, especially at Medication administration times. For the next four weeks, the Home Manager and/or Prograd Director will complete Medical Administration observations a minimum of twice weekly to ensure that all staff are completing all consumers Medication Administration goans written. Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goans written. 2. Comprehensive Functional Assessments for all consumer will be completed and placed the consumers file. The Program Director will recretraining on ensuring that all consumers have Comprehense Functional Assessments completed annually in accordance with the annual Individual Support plan. For the next 3 months, the Area Director will recreated the consumers of the program of the pr	als mal am ation als e ector als in eive sive	11/07/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				/EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED)
		15G466	B. WIN		·	10/08/2012	2
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8		1	75TH PL		
REM-INIT	DIANA INC				APOLIS, IN 46260		
	JANA INO			INDIAN	Al OLIO, IIV 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	W249.				will review all ISPs written by t		
					Program Director to ensure that	at	
	2 The OMRP fa	iled to ensure clients A			Comprehensive Functional		
	The state of the s	re reviewed annually.			Assessments are being		
		•			completed and the data collect is being utilized in the	.ea	
	Please see W259	₹.			development of training goals	and	
					objectives.	an 10	
	3. The QMRP fa	iled to ensure client A's			Program Director will update	,	
	ISP was reviewe	ed annually. Please see			and complete Client A's ISP. T		
	W260.				Program Director will review al		
					other consumers ISP dates an	d	
	4 The OMDD fo	illed to coordinate client			ensure that any others that are		
	`				not up to date are completed a	s	
		ensure the facility			soon as possible.		
	obtained written	informed consent from			The Program Director will rece		
	client B's legal re	epresentative prior to			retraining on the need to ensu	e	
	implementing a	restrictive program.			that all consumers ISPs are		
	Please see W263				completed annually before the expiration date. For the next 3		
	110050 500 11205				months, the Area Director will		
	7 TI OMBRC	21 1 2 2 2 2 2			review all ISPs written by this		
	7	ailed to coordinate clients			Program Director to ensure that	at	
	-	grams to ensure the			ISPs are being completed		
	clients' rights we	ere not violated by the			annually before the expiration		
	restriction of loc	king knives without due			date.		
		assessment of individual			4. The Program Director will		
	need. Please see				receive retraining on ensuring		
	need. I lease see	,, 201.			that consumers' guardians or		
	0.2.2()				Health Care Representatives a	ire	
	9-3-3(a)				notified of any additions or		
					changes to consumers' psychotropic medications and	anv	
					additions or changes to	arry	
					consumers Behavior Support		
					plans. The Program Director w	ill	
					also receive retraining on		
					ensuring that consumers'		
					guardians and/or Health Care		
					Representatives review and		
					approve any changes or updat	es	
					to psychotropic medications		
					l .		

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G466		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/08/2012	
	ROVIDER OR SUPPLIEF	1	STREET . 1926 W	ADDRESS, CITY, STATE, ZIP CO / 75TH PL IAPOLIS, IN 46260	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPL PROPRIATE DA	
				and/or Behavior Support prior to their implemental For the next 3 months, the Program Director will prodocumentation to the Ambirector that consumers guardians or Health Carrespesentatives have renotification of any change psychotropic medication Behavior Support Plans approved any changes. 3 month period, the Area will review the document guardians or Health Carrespesentatives are recupdated copies of consumentations. BSPs a minimum of qual ensure that these requires continue to be met. 5. The Program Director review the need for all corregarding restricted access, the form of the restriction is put into consumers Behavior Surplan and guardian and Heights Committee Approbationed. For other conthat do not require restricted access to the knives in the Home Manager and Director will develop a withem to have access to knives as needed such a key to where the knive locked up. The Program Director wiretraining on the need to the continue on the need to the continuentation of the need to the need to the continuentation of the need to the	tion. The povide ear of the ear of th	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 10/08		
	PROVIDER OR SUPPLIER	R	1926 W	ADDRESS, CITY, STATE, ZIP (/ 75TH PL IAPOLIS, IN 46260	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAU	REGULATORI UN	A CLOC IDENTIFICATION INFORMATION)	IAG	that Human Rights Co Approvals are obtaine restrictions recommer consumer prior to the being implemented. O Program Director will Human Rights Commi Approvals are obtaine restrictions recommer consumer prior to the being implemented. F Party: Home Manage Director, Area Directo	enmmittee and for any restrictions Congoing, the ensure that ittee and for any restrictions Responsible er, Program	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G466	B. WIN			10/08/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1926 W	75TH PL		
	IANA INC				APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
TAG W0249	483.440(d)(1) PROGRAM IMPL As soon as the in formulated a clier each client must it treatment prograr interventions and number and frequ achievement of the the individual program interview for 2 of and C), the facilit the clients B and during formal and opportunities. Findings include Observations we home on 10/2/12 8:00 AM. At 7:1 prompted by staff medication admit came to the medication admitister client medications. Staff encourage client administration of	terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan. ation, record review and if 3 sampled clients (B ty failed to implement in C training objectives id informal training The conducted at the group if from 6:00 AM through if AM client B was iff #3 to come to the nistration area. Client B ication administration in Staff #3 proceeded to	Wo	TAG 249	All Direct Care staff will receive retraining on all consumers Medication Administration goa and the need to complete form training goals as indicated, especially at Medication administration times. For the next four weeks, the Home Manager and/or Progran Director will complete Medication Administration observations a minimum of twice weekly to ensure that all staff are completing all consumers Medication Administration observations as written. Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goal as written.	e Is al	DATE 11/07/2012
	come to the med area. Client C ca administration ar proceeded to adm	ication administration me to the medication rea and sat down. Staff #3 minister client C's tions. Staff #3 did not			Responsible Staff: Home Manager, Program Director		

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED
	15G466	B. WING		10/08/2012
	PROVIDER OR SUPPLIER DIANA INC	1926 W 75TI	ESS, CITY, STATE, ZIP CODE TH PL DLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CRE TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	prompt or encourage client C to participate in the administration of her medication.			
	Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's ISP (Individual Support Plan) dated 3/23/12 indicated client B was not independent in medication administration and required additional training and supports. Client B's ISP indicated, "Daily, [client B] will state the name of a medication, the dosage, the color, the shape and one side effect with one verbal prompt or less 75% of the time for three consecutive months." Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's ISP dated 2/7/12 indicated client C was not independent in medication administration and required additional training and supports. Client C's ISP indicated, "Twice daily, [client C] will state what she is taking her medication for with two verbal prompts or less." Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated the staff should train clients at every available opportunity. QMRP #1 indicated formal and informal training should be occurring during medication administration times.			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		A. BUILDING B. WING			COMPLETED 10/08/2012	
	PROVIDER OR SUPPLIE		STREET A 1926 W	ADDRESS, CITY, STATE, ZIP CO 75TH PL APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	9-3-4(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G466	B. WIN			10/08/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
DEMINIS	NANIA INIO				/ 75TH PL		
REM-IND	DIANA INC			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0259	483.440(f)(2) PROGRAM MON At least annually, functional assess be reviewed by the relevancy and up Based on record 2 of 3 sampled of facility failed to CFA's (Comprehassessments) we Findings include 1. Client A's record 10/2/12 at 12:14 dated 7/27/09 dia assessment had be 2. Client B's record 10/2/12 at 10:08 undated. Interview with Q Retardation Profat 10:15 AM indicated client I had not been upon	ITORING & CHANGE the comprehensive ment of each client must ne interdisciplinary team for dated as needed. review and interview for lients (A and B), the ensure clients A and B nensive Functional ere reviewed annually.	W02		Comprehensive Functional Assessments for all consumer will be completed and placed i the consumers file. The Program Director will rece retraining on ensuring that all consumers have Comprehens Functional Assessments completed annually in accordance with the annual Individual Support plan. For the next 3 months, the Are Director will review all ISPs written by this Program Director to ensure that Comprehensive Functional Assessments are being completed and the data collected is being utilized in the development of training goals objectives. Responsible Party: Program Director, Area Director.	s n ive ive	11/07/2012
	, , , , , , , , , , , , , , , , , , , ,						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		15G466	A. BUIL			10/08/	2012
			B. WING		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
DEM IND	JANIA INIO				75TH PL		
REM-IND	IANA INC			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
W0260	483.440(f)(2) PROGRAM MON At least annually, must be revised, the process set for section. Based on record 1 of 3 sampled of failed to ensure of Support Plan) was Findings include Client A's record 10/2/12 at 12:14 (Individual Suppose) 8/11/11.	the individual program plan as appropriate, repeating orth in paragraph (c) of this review and interview for lients (A), the facility client A's ISP (Individual as revised annually.	W02	260	The Program Director will updated and complete Client A's ISP. The Program Director will review a other consumers ISP dates and ensure that any others that are not up to date are completed a soon as possible. The Program Director will receive retraining on the need to ensure that all consumers ISPs are completed annually before the expiration date. For the next 3 months, the Are Director will review all ISPs written by this Program Director to ensure that ISPs are being	The III III III III III III III III III I	11/07/2012
	Retardation Prof	Pessional) #1 on 10/3/12			completed annually before the expiration date.		
	have a more curr	rent ISP for review. ated client A's ISP should		Responsible Party: Program Director, Area Director			
	9-3-4(a)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				75TH PL		
REM-IND	DIANA INC				APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0263	483.440(f)(3)(ii) PROGRAM MON The committee sh programs are con- written informed of parents (if the clie- guardian. Based on record 1 of 3 sampled of psychotropic beh medications, the written informed B's legal represed implementation of Findings include Client B's record 10/2/12 at 10:08 3/23/12 indicated guardian. Client Support Plan) da use of Fluoxetine (impulse control milligram (behave Carbonate capsu (impulse control signed/approved client's sister/guar Interview with Q Retardation Prof at 10:15 AM ind should have give	ITORING & CHANGE nould insure that these inducted only with the consent of the client, ent is a minor) or legal review and interview for lients (B) with navior control facility failed to obtain a consent from the client intative prior to the of a restrictive program. I was reviewed on AM. Client B's ISP dated a client B's sister was her B's BSP (Behavior ited 6/30/12 indicated the expanded and capsule 40 milligrams and prior control) and Lithium le 300 milligrams. Client B's BSP was not by the client or the	W0:		The Program Director will rece retraining on ensuring that consumers' guardians or Healt Care Representatives are notifications and any additions changes to consumers Behavious Support plans. The Program Director will also receive retraining on ensuring that consumers' guardians and/or Health Care Representatives review and approve any change or updates to psychotropic medications and/or Behavior Support plans prior to their implementation. For the next 3 months, the Program Director will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received notification of any changes to psychotropic medications and Behavior Support Plans and heapproved any changes. After the 3 month period, the Area Director will review the documentation guardians or Health Care Representatives are receiving updated copies of consumers BSPs a minimum of quarterly to	th fied or or ges destor that	11/07/2012

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Event ID: 6S6P11

Facility ID: 000980

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PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDI	ENTIFICATION NUMBER: 5G466	A. BUILDING B. WING	00	COMPLETED 10/08/2012
	ROVIDER OR SUPPLIER		1926 W	ADDRESS, CITY, STATE, ZIP CODE 775TH PL APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	approval/implemen program.	tation of the restrictive		ensure that these requirement continue to be met.	s
	9-3-4(a)			Responsible Party: Program Director, Area Directo	or

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6S6P11

Facility ID: 000980

If continuation sheet

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC INDIANAPOLIS, IN 46260 INDIANA	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0264 W0264 W0264 W0264 REGULATORY OR LSC IDENTIFYING INFORMATION) W0264 W0266 A Based on observation of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of clocking knives without due process SWING SWING STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260 ID PROVIDERS PLAN OF CORRECTION (AS) (CACH OERECTIVE ACTION SIROLL DIE: CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE W0264 TAG W0264 The Program Director will review the need for all consumers regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W0264 W0264 W0264 W0364 W0364 W0366 W0			15G466				10/08/	2012
REM-INDIANA INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W0264 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process				D. 11111		ADDRESS, CITY, STATE, ZIP CODE		
REM-INDIANA INC INDIANAPOLIS, IN 46260	NAME OF P	ROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG W0264 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process Program Director will review the need for all consumers need restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the	REM-IND	IANA INC						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0264 W0264 PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process								
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PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process			LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process	VVU264		IITOPING & CHANGE					
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and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the			·	*** 02	204	_	. vv	11/0//2012
constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the			* '				the	
Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process Committee) failed to ensure the clients' need restricted access, the Program Director will ensure that the restriction is put into the		, .						
rights were not violated by the restriction of locking knives without due process Program Director will ensure that the restriction is put into the			`				s	
of locking knives without due process the restriction is put into the		,						
		~	•				nat	
I Consumers Benavior Support		of locking knives	s without due process			consumers Behavior Support		
through assessment of individual need. Plan and guardian and Human		through assessme	ent of individual need.				1	
Rights Committee Approval is							•	
Findings include: obtained. For other consumers		Findings include						
that do not require restricted		1 111411185 11141444	•			that do not require restricted		
Observations were conducted at the group		Observations we	era conducted at the group					
Observations were conducted at the group the Home Manager and Program								
home on 10/1/12 from 4:51 PM through Director will develop a way for			· ·			-		
6:00 PM. At 5:10 PM staff #1 was them to have access to the knives as needed such as having							ina	
assisting clients A, B and C with the		•	·				9	
evening meal preparation in the group locked up.		evening meal pre	eparation in the group			•		
home kitchen. Staff #1 exited the kitchen		home kitchen. St	aff #1 exited the kitchen			•		
and entered the group home living room		and entered the g	group home living room					
area where the medication cabinet was The Program Director will receive		area where the m	nedication cabinet was					
located. Staff #1 approached the retraining on the need to ensure		located. Staff #1	approached the					
medication administration area where that Human Rights Committee Approvals are obtained for any						_		
staff #2 was preparing medication for restrictions recommended for any								
			_					
administration and stated, if field a kinic heing implemented						T		
and removed a knife from the medication								
cabinet. At 5:45 PM staff #1 washed the Ongoing, the Program Director		cabinet. At 5:45	PM staff #1 washed the			Ongoing, the Program Director	r	

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Event ID: 6S6P11

Facility ID: 000980

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PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

15G466 B. WING 10/08/2012	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM-	(X5) PLETION DATE
knife at the kitchen sink and returned the knife at the kitchen sink and returned the knife to the medication administration cabinet. Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's ISP (Individual Support Plan) dated 8/11/11 did not indicate client A needed or required to be restricted from access to knives. Client A's record did not indicate the need for restricted access to knives. Client A's record failed to indicate the HRC had reviewed the facility practice of restricted from access to and/or the use of knives. Client B's EPA dated 6/30/12 did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's record failed to indicate client B needed to be restricted from access to and/or the use of knives. Client B's record failed to indicate client B needed to be restricted from access to and/or the use of knives. Client B's record failed to indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives.	DATE

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Event ID: 6S6P11

Facility ID: 000980

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PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	OF CORRECTION	15G466	A. BUII	LDING	00	10/08/	
		130400	B. WIN			10/00/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				75TH PL APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	guardian/surroga	ite approval.					
	Client C's record 10/2/12 at 1:09 F 2/7/12 did not in be restricted from of knives. Client did not indicate of restricted from a knives. Client C' not indicate clier restricted from a knives. Client C' the HRC had rev practice of restricted from a knives	I was reviewed on PM. Client C's ISP dated dicate client C needed to m access to and/or the use C's BSP dated 9/1/12 client C needed to be ccess to and/or the use of s CFA dated 4/22/12 did not C needed to be ccess to and/or the use of s record failed to indicate riewed the facility compact access to knives ent, program, or the approval. PMRP (Qualified Mental dessional) #1 on 10/3/12 iccated the group home in the medication #1 indicated client A, B we product misuse or exthreat of use of knives RP #1 indicated client A, have a key to access the use. QMRP #1 indicated es was a rights restriction					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
	NANIA INIC				75TH PL		
KEIVI-IINL	DIANA INC			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
W0331	483.460(c)						
	NURSING SERV	ICES					
		provide clients with nursing					
	services in accord	dance with their needs.					
	Based on observ	ation, record review and	W0:	331	Client B Fall Risk Protocol		11/07/2012
	interview for 2 o	f 3 sampled clients (B			has been completed. The		
		ty nursing services failed			Program Nurse will be retrained		
	, · · · · · · · · · · · · · · · · · · ·	prevention protocol for			on ensuring that protocols are		
	_				developed as needed based o	n	
		ility's nursing services			consumers risk and needs.	•••	
	failed to ensure of	clients B and C had			Ongoing, the Program Nurse v	VIII	
	recommended ac	laptive equipment.			ensure that protocols are developed as needed based o	n	
					consumers documented risks		
	Findings include				needs. Program Nurse will	ana	
		•			ensure that all staff are trained	lon	
	1. Cli Dl				any protocols that are develop	-	
		ord was reviewed on			based on consumers risks and		
		AM. Client B's Quarterly			needs.		
	Nursing Assessn	nent indicated the			2. Training goals have been		
	following:				developed for Client B to prom		
	_				her to wear her eyeglasses ar		
	-3/30/11 note ind	licated, "abnormal gait"			use her walker. All Direct Supp	oort	
	with fall at work	_			Staff will receive training on	_	
	with fair at work	reported.			implementing Client B's trainin		
					goals for her adaptive equipme Program nurse will follow up o		
	-6/7/11 note indi	cated, "abnormal gait."			the recommendation for Client		
					for use of a Occlusal Mouthgu		
	-9/13/11 note inc	licated, "abnormal gait."			and Rigid Orthotics for her fee		
		,			Program nurse will ensure this		
	12/1/11 note inc	dicated, "abnormal gait"			adaptive equipment has been		
		•			obtained and staff are trained	on	
	with one fall rep	опеа.			the use of this adaptive		
					equipment. The Program		
	-3/13/12 note inc	licated one fall reported			Director will receive retraining		
	while in the show	wer due to an, "abnormal			include the need to ensure tha		
	gait."	,			consumers have training goals		
	, Durin				developed and implemented to		
	(/11/10 / 1:	. II 4 . 1 . II 4 D 1 . 14			provide support for them to use	E	
		ndicated client B had two			their adaptive equipment.	<u>,</u>	
	falls this quarter	and was receiving			Ongoing, the Program Director	ı	

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-	OF CORRECTION	IDENTIFICATION NUMBER: 15G466	A. BUIL B. WING	DING	00	COMPLETED 10/08/2012	
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE 75TH PL		
REM-INI	DIANA INC			INDIAN	APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	and balance. -9/11/12 note indigest month. Rolled delivered today." Client B's Medic dated 5/9/12 indictreat for a small fiscoliosis, frequer management. See Therapy) evaluat pain and gait about 2. Observations we group home on 1 through 6:00 PM were observed in observation period utilize a rolling wor hearing aids diperiod. Client Conguard or foot orthe Observations we home on 10/2/12 8:00 AM. Client observed in the hobservation period utilize a rolling wor hearing aids diperiod.	al Appointment form cated, "Evaluate and fracture lower spine, at falls and pain en for PT (Physical ion regarding low back formality." were conducted at the 0/1/12 from 4:51 PM Client B and client C the home throughout the bad. Client B did not walker, wear eyeglasses uring the observation did not utilize a mouth notic device. The conducted at the group from 6:00 AM through B and client C were some throughout the bad. Client B did not walker, wear eyeglasses uring the observation did not utilize a mouth of the bad. Client B did not walker, wear eyeglasses uring the observation did not utilize a mouth of the base of the			will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Responsible Party: Program Nurse, Nursing Supervisor, Program Director, Area Director	m S D D	

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL	
ANDILAN	OF CORRECTION	15G466		LDING		10/08/	
		130400	B. WIN	_		10/00/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 7 75TH PL		
REM-IND	DIANA INC				APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Cli / Dl						
		was reviewed on					
		AM. Client B's vision					
		ment form dated 6/8/11					
		ommendation for full					
		use. Client B's hearing					
	appointment for						
		ommendation for full					
		ng aids. Client B's dental					
		n dated 2/27/12 indicated					
		tion for use of a bite					
	~	Quarterly Nursing					
		d 9/11/12 indicated client					
	B had an PCP (P	•					
		iption order for a rolling					
		's Quarterly Nursing					
		1 9/11/12 indicated client					
		he rolling walker for full					
		B's ISP (Individual					
		ted 3/23/12 did not					
		nformal training or					
	supports to assis	t client B to use					
	eyeglasses, heari	ng aids or the rolling					
	walker.						
	Client C's record	was reviewed on					
		PM. Client C's physicians					
		8/27/12 indicated the					
		hotic daily (plantar					
	_	clusal Mouthguard					
	(TMJ/Temporon						
	_	it C's Monthly Health					
	· ·	on form dated August					
		lient C should be using a					
	2012 maicated C	ment e should be using a					

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OF CORRECTION	15G466	A. BUI	LDING	00	10/08/	
		130400	B. WIN			10/00/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				75TH PL APOLIS, IN 46260		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	mouthguard and	have orthotics for her					
	feet.						
	Interview with C	MRP (Qualified Mental					
		Sessional) #1 on 10/3/12					
		icated client B's guardian					
		garding her ambulation					
	_	e walker. QMRP #1					
	•	at B] sometimes has					
		nce." When asked if					
	client B had a hi	story of falls, QMRP #1					
	stated, "[Client F	B] has had a few, two or					
	three since I've b	been here. I've been here a					
	couple of month	s." QMRP #1 indicated					
	client B did not l	nave a fall risk prevention					
	plan. QMRP #1:	indicated client B should					
	wear eyeglasses,	hearing aids and use her					
	~	QMRP #1 indicated client					
	B refused to wea	r her eyeglasses and use					
	`	RP #1 indicated client B's					
		e being adjusted due to					
		rly and falling out.					
	-	ated client B did not have					
	_	train/assist her to use her					
	eyeglasses or wa	-					
	indicated client I						
	` `	IRP #1 indicated client C					
		outhguard or orthotics for					
	her feet.						
	Interview with n	urse #1 on 10/3/12 at					
	10:30 AM indica	nted client B had a history					
	of falls. Nurse #3	l indicated client B's PCP					
	(Primary Care Pl	hysician) had written a					
							ı

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	of Correction identification number: 15G466	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE COMPL 10/08/	ETED				
REM-IND	PROVIDER OR SUPPLIER	1926 V	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE				
	prescription for client B to use a rolling walker while ambulating. Nurse #1 indicated client B needed a falls risk plan.								
	9-3-6(a)								

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				75TH PL		
REM-IND	DIANA INC				APOLIS, IN 46260		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0356	483.460(g)(2) COMPREHENSING The facility must of dental treatment of care needed for restoration of teed dental health. Based on record 2 of 3 sampled of facility failed to timely recomment. The facility failed attended schedul. Findings include 1. Client A's reconstruction and the second of th	VE DENTAL TREATMENT ensure comprehensive services that include dental elief of pain and infections, th, and maintenance of review and interview for lients (A and B), the ensure client A received inded dental treatment. It does not ensure client B ed dental appointments. The properties of the proper	Wo		1. Home Manager, Program Director and Program Nurse was be retrained on the need to fol up to ensure all clients are receiving dental treatment as recommended. They will also retrained that if there are issue with a dentist getting paperwork to submit for dental services or paid through Medicaid they are notify the Area Director to secupayment so that clients can receive services they need in a timely manner. Area Director work with Program Nurse to determine what paperwork is needed to submit for payment Client A's recommended dental treatment. 1.Al I Direct Care staff and Home Manager will receive retraining on the need to ensure consumers medical and dental appointments are kept as scheduled. If an appointment to be cancelled for any reason Direct care staff will notify the Home Manager and Program Nurse as to the reason the appointment was missed or rescheduled so they can follow to ensure all necessary appointments are completed.	be es rk ot e to ure a will for al	11/07/2012

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		15G466	A. BUI. B. WIN			10/08/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			75TH PL	
REM-IND	DIANA INC				APOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	MANUFACTOR N. AN OF CONDUCTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	RECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	2012 indicated t	he root canal was				
		13/12 but dentist refused			Ongoing, the Program Nurse a	and
	to complete the root canal without				Home Manager will ensure tha	
	-				there is follow up with medical	
		t due to Medicaid refusal			professionals to obtain paperw	
	to cover the cost	S.			when recommended services not covered by Medicaid. If	are
	2 Cliant Pla rag	ord was reviewed on			responses are not received fro	
					the medical professionals, the	
		AM. Client B's June			HM and Program Nurse will	
	_	rogress notes indicated,			consult with the Area Director	
	"Dentist called s	tating, [Client B] did not			work out a plan so recommend	ded
	show for schedu	led appointment today			services are paid so that consumers can receive	
	and that this was	s the third or fourth time			recommended treatment.	
		B's July 2012 Nursing			recommended treatment.	
		ndicated, "[Dentist],			Ongoing, the Program Nurse a	and
					Home Manager will meet a	
		client B] missed her			minimum of monthly to review	all
		ent today, stated [client			consumer medical/dental	
	B] has missed th	ree in a row and dentist			appointments scheduled for th	
	refuses to treat [client B] in the future."			following month. Home manage	ger
					and Program Nurse will work	
	Interview with OM	RP (Qualified Mental			together to ensure all appointments are being	
		sional) #1 on 10/3/12 at 10:15			completed or rescheduled as	
	AM indicated clien				needed. If there are ongoing	
		r a root canal and crown			issues with a particular consur	mer
	replacement.				not keeping the medical	
					appointments, the Program Nเ	
		e #1 on 10/3/12 at 10:30 AM			and Home Manager will consu	llt
		ad a 2/20/12 recommendation			with the Program Director to	
		crown replacement. Nurse #1			determine if the issues are a	
		t had not completed the			result of client refusals, etc. or	
		for the facility to issue a check			staff not keeping appointments the issues are a result of client	
		#1 indicated client A should			refusals the IDT team will mee	
		mended services prior to the			problem solve how to ensure t	
		rse #1 indicated client B had			consumer is getting to	
		intments and was scheduled to			appointments. If the issues are	e a
	start services with a	i new dentist.			result of staff not keeping	
	9-3-6(a)				appointments, the Program	
)) ((u)				I	1

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	(X2) MULTIPLE CO A. BUILDING B. WING	00		SURVEY LETED 5/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)		(X5) COMPLETION DATE	
				Director will evaluate if action for staff is neces:	sary.		
				Responsible Party: Ho Manager, Program Dire Director, Program Nurs	ector, Area		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G466	A. BUILDING B. WING		10/08/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		V 75TH PL	
DEM IND	DIANA INC			NAPOLIS, IN 46260	
	MANA INC		INDIAN	NAFOLIS, IN 40200	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0369	483.460(k)(2)				
	DRUG ADMINIS				
		Irug administration must			
		rugs, including those that ered, are administered			
	without error.	ered, are administered			
		vation, record review and	W0369	All staff will receive retraining	on 11/07/2012
		·	W 0307	all consumers medication order	
		of 3 sampled clients (B),		including Client B	
	_	d to ensure staff		Cholestyramaniene powder	
		edication as ordered for 8		needing to be given 1 hour aft	er
	missed of 31 me	edication doses.		all other medications.	
				1	
	Findings include	e:		Home Manager and/or Progra	
				Director will complete medicat administration observations at	
	Observations we	ere conducted at the group		least twice per week for four	
		2 from 6:00 AM through		weeks to ensure that all staff a	are
		•		following all consumers	
		11 AM client B was		medication orders as written.	
		Iff #3 to come to the			
	medication adm	inistration area to receive		Ongoing, the Home Manager	
	her morning me	dications. Client B		and/or Program Director will	
	received 1 Ranii	tidine (ulcers) tablet 150		complete medication	
	milligram, 1 Lit	hium Carbonate (bipolar)		administration observations at	
	•	1 Gabapentin (seizures)		least once per week to ensure that all staff are following all	
		grams, 1 Oyster Shell		consumers medication orders	as
	_	-		written.	
	`	ement) tablet 500			
	•	hera (supplement) tablet, 1		Responsible staff: Home	
	Levetiracetam (seizures) tablet 100		Manager, Program Director	
	milligrams, 1 Fl	uvoxamine (obsessive			
	compulsive disc	order) capsule 40			
	milligrams, Cho	olestyramine Powder			
	•	grams, Denta 5000 cream			
		health), Elidel cream 1%			
	• `	etoconazole cream 2%			
	` 1 /	Stoconazore cream 270			
	(topical).				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE S COMPLI	
ANDILAN	or connection	15G466	A. BUI	LDING	00	10/08/	
		130400	B. WIN			10/00/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				75TH PL APOLIS, IN 46260		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		was reviewed on					
		AM. Client B's MAR					
	,	ninistration Record)					
		rough 10/31/12 indicated,					
	_	powder 4 gram lite give					
		. at 8:00 AM." Client B's					
	I -	alting Form dated 2/13/12					
	note to nursing in	ndicated, " please note:					
	Cholestyramine j	powder should be					
	administered sep	arate from other					
	medications due	to the possible					
	interference of absorption of medications						
	and thus making	them less effective. All					
	other medication	should be taken one					
	hour before or 4-	6 hours after					
	cholestyraramine	e. Recommend making an					
	adjustment to the	e current administration					
	time (7 am) to be	e given one hour after					
	other 7 am sched	luled medications.					
	Cholestyramine	changed to 8 am on					
	3/1/12."	_					
	Interview with n	urse #1 on 10/3/12 at					
	10:30 AM indica						
	Cholestyramine	powder should not be					
		h other medications.					
	Nurse #1 indicate	ed client B's					
		powder should be					
		e hour prior to other					
	medications or 4	-					
	medications.						
	9-3-6(a)						
	, , , , (u)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466			(X2) MULTIPLE CO A. BUILDING B. WING	00		SURVEY LETED 5/2012
NAME OF P	ROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP CC / 75TH PL	DDE	
REM-IND	DIANA INC			APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
						1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				75TH PL		
RFM-IND	DIANA INC				APOLIS, IN 46260		
		FATEMENT OF DEPICIENCIES	1	ID		1	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
W0382	483.460(I)(2)	ESC IDENTIFICATION OR MATTERN		1110			DATE
VVU302		E AND RECORDKEEPING					
		keep all drugs and					
		I except when being					
	prepared for adm						
	Based on observ	ation and interview for 3	W0	382	All staff will receive retraining	on	11/07/2012
	of 3 sampled clients (A, B and C) plus 3				ensuring that the medication		
	additional clients	s (D, E and F), the facility			cabinet is locked during	_	
		nedications were			medication administration whe exiting the medication area for		
		secure location during the		any reason.			
		nistration process.			arry reason.		
	incarcation admi	institution process.			Home Manager and/or Progra	m	
	Findings in alada				Director will complete medicati		
Findings include:				administration observations at			
					least twice per week for four		
		re conducted at the group			weeks to ensure that all staff a locking the medication cabinet	-	
	home on 10/2/12	2 from 6:00 AM through			during medication administration		
	8:00 AM. At 7:2	3 AM staff #3 exited the			when staff are out of the area		
	medication admi	nistration area with client			any reason.		
	B to brush her te	eth. Staff #3 did not lock			-		
	the medication c	abinet where clients A,			Ongoing, the Home Manager		
		's medications were			and/or Program Director will		
		AM client C entered the			complete medication		
		nistration area with no			administration observations at least once per week to ensure		
					that all staff are locking the		
		A staff #3 exited the			medication cabinet during		
		nistration area to get			medication administration whe	n	
	client E from the	kitchen for her morning			staff are out of the area for any	/	
	medication. Staf	f #3 did not lock the			reason.		
	medication cabir	net when she exited the					
	medication admi	nistration area.					
	Interview with st	taff #3 on 10/2/12 at 7:23					
	AM indicated the						
		abinet should be locked					
	when staff are no						
	when starr are no	or in the area.					

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G466	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/08/2012
REM-INI	PROVIDER OR SUPPLIER	1926 W	ADDRESS, CITY, STATE, ZIP CODE 775TH PL APOLIS, IN 46260	3
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	Interview with nurse #1 on 10/3/12 at 10:30 AM indicated the medication administration cabinet contained the medications for clients A, B, C, D, E and F. Nurse #1 indicated the medication cabinet should not be left unlocked without staff present in the area. 9-3-6(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G466	B. WIN			10/08/	2012
NAME OF I	DROVADED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1926 W	/ 75TH PL		
	DIANA INC			INDIAN	IAPOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
W0436	repair, and teach informed choices eyeglasses, heard communications a devices identified team as needed to Based on observations and aptive equipm failed to ensure of walker, eyeglass in the group homensure client C high guard and foot of Findings include Characteristics of the Based on observations were client C high guard and foot of Findings include Characteristics of the Based on 10/1/12 6:00 PM. Client observation period in the Based on 10/2/12 guard or foot ortion Characteristics were home on 10/2/12 8:00 AM. Client observed in the Based on the Based o	furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. ation, record review and if 3 sampled clients with ent (B and C), the facility client B utilized a rolling es and hearing aids while he. The facility failed to had and utilized a mouth rithotic device. The conducted at the group of from 4:51 PM through B and client C were nome throughout the bod. Client B did not walker, wear eyeglasses suring the observation did not utilize a mouth thotic device. The conducted at the group of from 6:00 AM through B and client C were nome throughout the bod. Client B did not conducted at the group of from 6:00 AM through B and client C were nome throughout the bod. Client B did not	WO	436	Training goals have been developed for Client B to prom her to wear her eyeglasses an use her walker. All Direct Supports Staff will receive training on implementing Client B's training goals for her adaptive equipmed. Program nurse will follow up on the recommendation for Client for use of a Occlusal Mouth guand Rigid Orthotics for her feet Program nurse will ensure this adaptive equipment has been obtained and staff are trained of the use of this adaptive equipment. The Program Director will receive training to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Ongoing, the Program Director will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3	d poort g ent. n C uard t. on	11/07/2012
	8:00 AM. Client observed in the h observation period	B and client C were nome throughout the			and implemented to provide support for them to use their		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		ĺ	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 10/08/	ETED	
NAME OF PI	ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE 775TH PL APOLIS, IN 46260	ı	
REM-IND (X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR or hearing aids d period. Client C guard or foot ort Client B's record 10/2/12 at 10:08 medical appointr indicated the rec- time prescription appointment forr recommendation hearing aids. Clie examination forr the recommenda guard. Client B's Assessment date B had an PCP (P prescription orde Client B's Quarte dated 9/11/12 inc received the rolli use. Client B's IS Plan) dated 3/23/ formal/informal assist client B wi hearing aids or th Client C's record 10/2/12 at 1:09 F order form dated use of Rigid Ortl fasciitis) and Oct TMJ (Temporori	AM. Client B's vision ment form 6/8/11 commendation for full use. Client B's hearing in 3/22/11 indicated the for full time use of ent B's dental in dated 2/27/12 indicated tion for use of a bite. Quarterly Nursing d 9/11/12 indicated client rimary Care Physician) or for a rolling walker. Early Nursing assessment dicated client B had ing walker for full time. SP (Individual Support 1/12 did not indicate training or supports to the use of eyeglasses, the rolling walker. Was reviewed on PM. Client C's physicians 8/27/12 indicated the notic daily (plantar clusal Mouthguard for		INDIAN. ID PREFIX TAG	APOLIS, IN 46260 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) ISPs submitted by this Progration Director to ensure that all consumers have training goad developed and implemented provide support for them to u their adaptive equipment. Responsible Party: Program Nurse, Nursing Supervisor, Program Director, Area Director Di	am Is to se	(X5) COMPLETION DATE

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Facility ID: 000980

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL 10/08/	
		15G466	B. WIN	IG		10/08/	2012
NAME OF I	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
DEM INIT	DIANA INC				75TH PL APOLIS, IN 46260		
				<u> </u>	APOLIS, IN 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		·		TAG	DEFICIENCE!		DATE
		on form dated August					
		lient C should be using a					
	mouthguard and have orthotics for her						
	feet.						
	T	NADD (O. 116 134 + 1					
		OMRP (Qualified Mental					
		Fessional) #1 on 10/3/12					
		licated client B should					
		hearing aids and use her					
rolling walker. QMRP #1 indicated client							
	B refused to wear her eyeglasses and use						
	her walker. QMRP #1 indicated client B's						
	_	e being adjusted due to					
		rly and falling out.					
	QMRP #1 indica	ated client B did not have					
	a formal goal to	assist/train her to use her					
	eyeglasses or wa	ılker. QMRP #1 indicated					
	client B did not l	have a mouthguard.					
	QMRP #1 indica	ated client C did not have					
	a mouthguard or	orthotics for her feet.					
	9-3-7(a)						

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Event ID: 6S6P11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED	
		15G466	B. WIN			10/08/	/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	t			/ 75TH PL			
REM-IND	DIANA INC				IAPOLIS, IN 46260			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0440	483.470(i)(1) EVACUATION DITHE facility must be least quarterly for Based on record 3 of 3 sampled cadditional clients failed to hold every quarter on each surface on the facility's evareviewed on 10/2 review indicated conduct evacuati (A, B, C, D, E and home for the first through March 2 through 7:00 AM to conduct evacuation drills 2012 for the 7:00 shift. The facility evacuation drills 2012 through Se 3:00 PM through Interview with CR Retardation Profest 10:15 AM indicated the conduct evacuation drills 2012 through Se 3:00 PM through Interview with CR Retardation Profest 10:15 AM indicated the conduct evacuation drills 2012 through Se 3:00 PM through Interview with CR Retardation Profest 10:15 AM indicated the conduct evacuation drills 20:15 AM indicate	RILLS hold evacuation drills at reach shift of personnel. review and interview for lients (A, B and C) plus 3 s (D, E and F), the facility acuation drills for each shift of personnel. Exacuation drills were 2/12 at 10:03 AM. The lithe facility failed to ion drills for 6 of 6 clients and F) living in the group st quarter, January 2012 gold for the 11:00 PM. A shift. The facility failed nation drills for the April 2012 through June 20 AM through 3:00 PM. The facility failed to conduct a for the third quarter, July ptember 2012 for the in 11:00 PM shift. EXACUATION OF THE PROPERTY OF	WO		All Direct Support Professional will receive a retraining at least every other month to ensure the they understand the important of completing the monthly fire drills. The training will include reviewing a copy of the fire drischedule. Ongoing, the Direct Support Professionals will complete on fire drill per month (or more as needed) according to the schedule to ensure that the he and safety of the client's need are met. Ongoing, the completed fire directive will be turned in to and reviewed by Quality Assurance for accuracy and thoroughnes each drill. Responsible Staff: Home Manager, Program Director, Quality Assurance	et nat ce II ee salth s	11/07/2012	
	<i>J-J-1</i> (α)				1		1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		A. BUILDING B. WING	00	COM	E SURVEY PLETED 18/2012	
	PROVIDER OR SUPPLIER		STREET A 1926 W	ADDRESS, CITY, STATE, ZIP C 775TH PL APOLIS, IN 46260	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE I DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G466	A. BUII B. WIN			10/08/	2012
			b. Why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				75TH PL		
REM-IND	DIANA INC				APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0455	483.470(I)(1) INFECTION CON There must be an prevention, contro infection and com Based on observ of 3 sampled clie additional client ensure clients was hands prior to or administration. Findings include Observations we home on 10/2/12 8:00 AM. At 7:1 prompted by staff medication administer client medications. State encourage client hands prior to ha At 7:29 AM clies staff #3 to come administration at medication admi	active program for the pol, and investigation of inmunicable diseases. action and interview for 2 ents (B and C) plus 1 (D), the facility failed to ashed or sanitized their during medication et action and interview for 2 ents (B and C) plus 1 (D), the facility failed to ashed or sanitized their during medication et action 6:00 AM through 1 AM client B was ff #3 to come to the inistration area. Client B ication administration in Staff #3 proceeded to B's morning ff #3 did not prompt or B to wash or sanitize her andling her medication. Int C was prompted by to the medication rea. Client C came to the inistration area and sat roceeded to administer ing medications. Staff #3 in encourage client C to ition her hands prior to	W04		All Direct Care staff will receive retraining on ensuring that all consumers wash or use hand sanitizer on their hands prior to receiving their medications to prevent spread of infection. Ho Manager and/or Program Direction administration observations at least twice per week for four weeks to ensure that all staff a ensuring that consumers are washing or using hand sanitize on their hands prior to receiving their medications. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are ensuring that consumers are washing or using hand sanitizer on their hands prior to receiving their medications. Responsible Part Home Manager, Program Director	ome ctor are er g e m ion	11/07/2012
		-					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G466		LDING	00	COMPL 10/08/	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Interview with n 10:30 AM indica	urse #1 on 10/3/12 at atted clients should wash hands prior to medication					
	9-3-7(a)						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIJII DING 00		00	COMPLETED	
		15G466	A. BUILDING			10/08/2012	
			B. WIN		A DODDEGG CHEV CHARE THE CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					/ 75TH PL		
REM-IND	DIANA INC			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
W9999							
	State Findings		WA	999	All Direct care staff will be rec	oivo	11/07/2012
	State 1 manigs		"	,,,	retraining on incident reporting		11/0//2012
	The Callessine Ca	it. Daridantial			requirements including what	9	
		mmunity Residential			incidents need to be reported,		
		ons with Developmental			designated timeframes in which		
	Disabilities rule w	vas not met.			incidents are to be reported ar		
					the procedure for immediately		
	460 IAC 9-3-1 Go	overning Body			notifying the on call supervisor		
	(b) The residentia	l provider shall report the			reportable incidents.		
	following circums	stances to the division by					
	telephone no later	than the first business day			The Home Manager will receive	ve	
	_	en summaries as requested			retraining on documentation		
	by division.	on summer us requested			review including reviewing all		
	by division.				consumer Daily support record		
	This mula was not	mat as avidenced by			behavior tracking and narrativ		
	This fulle was not	met as evidenced by:			notes to ensure all incidents th	nat	
					have been documented have		
		eview and interview for 2			been reported to the Program		
	_	of abuse, mistreatment or			Director so reports can be ma		
	neglect reviewed,	the facility failed to			to the Bureau of Development	iai	
	immediately notif	y BDDS (Bureau of			Disability Services and investigations can be complete	od	
	Developmental D	isabilities Services) within			as needed.	eu	
	24 hours regardin	g an incident of medication			as needed.		
		g client B. The facility			Ongoing, the Home Manager		
		tely notify BDDS regarding			and/or Program Director will		
		ents D, E and F's missing			review the DSRs and Behavio	or	
	petty cash.	onto D, L and I o missing			tracking records a minimum of		
	petty cash.				twice weekly for 30 days to		
	F: 1: 1 1				ensure that all incidents that fa	all	
	Findings include:				under the BDDS reportable		
					incident guidelines are reporte	ed to	
	The facility's BDI	_			the on call supervisor, Progra	ım	
		re reviewed on 10/2/12 at			Director and/or Area Director		
	8:50 AM. The rev	view indicated the			within the designated reporting	-	
	following:				guidelines. After the 30 days,		
					Home Manager and/or Progra		
	-BDDS follow up	report dated 8/31/12			Director will review the DSRs	and	
		B] missed the following			Behavior tracking records a		
I	i marcacca, [circiit	L I missed the following	1		minimum of once per week to		I

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
15G466		B. WING		10/08/2012				
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	ı			
NAME OF P	PROVIDER OR SUPPLIER	I.		V 75TH PL				
REM-INDIANA INC				INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		5.112			
		er Shell Calcium with		ensure that all incidents that fa	all			
	Vitamin D 500 mi	illigrams (supplement) and		under the BDDS reportable				
		ligram (impulse control)."		incident guidelines are reporte the on call supervisor, Prograi				
	1	indicated, "The on call		Director and/or Area Director	"			
	nurse was contact	ed by staff, [staff #1], on		within the designated reporting	a			
		M regarding the medication		guidelines.				
		oticed the error (medication						
		oinet but [staff #2] had		Responsible Party: Home				
		medication was given).		Manager, Program Director, A	rea			
		ormed the house nurse on		Director				
	8/27/12. This hom	ne is in between home						
	_	ough one home manage is						
	helping cover the	home the 6 day difference						
		nmunication. Program						
	director was not n	nade aware of the error and						
	able to get clarification until 8/29/12 and made the report right away."							
	-BDDS report dat	ed 9/11/12 indicated,						
		n to staff on the evening of						
		a lock box. Later that						
	_	some of the consumers to						
	-	ne next morning when staff						
		onsumers out [client D] was						
		client E] was missing \$5.00						
	and [client F] was	_						
	, , , , , , , , , , , , , , , , , , , ,							
	Interview with AS	S (Administrative Staff) #2						
		4 AM indicated BDDS						
	reportable inciden	ts included medication						
	1	ents' missing petty cash						
		cated BDDS reportable						
		be reported to BDDS within						
	24 hours of the da							
	9-3-1(b)							
			I					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G466		A. BUILDING	00	COMPLETED 10/08/2012			
		100100	B. WING	ADDDECC CITY CTATE 710 CODE	10/00/2012		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL						
	DIANA INC		INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)	TAG	,	DATE		

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